MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, November 15, 2001
10:09 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

Agenda item:
Blood safety requirements: impact on hospital costs and payment options
Tim Greene

MR. GREENE: Good afternoon. I will be discussing the revised BIPA mandated report on the treatment of blood costs under the inpatient PPS, as well as the recommendation that you discussed last month.

As we noted then, hospital blood-related costs have increased more rapidly than overall operating costs. The hospital marketbasket, which largely determines PPS updates may not appropriately reflect changes in the price of blood products. This may lead to inappropriately low updates in coming years if blood-related costs associated with new technologies increase.

BIPA required MedPAC to conduct a study on increased costs associated with blood safety requirements and new technologies required to meet them. It also require that you consider changes to the inpatient PPS to adjust future cost increases.

Last month I presented an overview of the draft report to Congress. Your briefing material includes a revised version of this report. We made changes to reflect the discussion last month, to incorporate the results of new analyses, and to include the text of the recommendation that you discussed. We will incorporate your comments today when we revise the report. We will not take it up again. However, we will send you a copy of the final report as revised before it's submitted to Congress on December 21st.

This is a review of where we were last month. As we discussed then, we examined growth in total hospital blood-related costs per discharge for all PPS cases and for discharges for beneficiaries who use blood alone. In both cases, blood-related costs grew somewhat faster than overall hospital operating costs.

The results you see in table three of the revised report in your briefing material update the results you saw last month. We used a larger sample of 1986 cases to develop these numbers, a 20 percent sample of patient stays rather than a 5 percent sample, and got somewhat different results. In particular, we got slightly lower growth rates in blood costs per discharge and overall costs per discharge. But exactly the same differential between growth rate for blood costs and growth rate for other.

So the results, in that regard, are the same as the ones you saw last month. Blood-related costs per discharge grow at 0.6 of a percentage point more than overall costs. As with last month, we found very little impact of blood cost growth on overall hospital costs.

We can update some information we presented last month that got people's attention, I think. At that point we informed you of a July 1st Red Cross blood product price increase that we were citing as a 35 percent increase. We looked into it further and

found that Red Cross had announced a 10 percent to 35 percent range of price increases to different hospitals at different points in their contract cycle, and so on.

An AHA survey of some of its members found a 26 percent -- not a 35 percent, a 26 percent -- increase in the price of blood purchased from Red Cross and a 12 percent increase in price from independent blood banks. That translates into an overall 21 percent price increase of blood from 2000 to 2001. You should think of that, rather than the much higher 35 percent number we quoted last time.

We showed you these options at the October meeting. You gave preliminary approval to the first, the marketbasket option, but did not adopt any of the other three. I will summarize them briefly at this time and give some information on them.

In the second option, blood safety costs would be treated as costs of technological change. However, your new update framework does not include costs for technological change or other add-ons except in exceptional cases. Blood safety technologies which affect a very small share of overall hospital costs may not qualify as exceptional cases for this purpose.

In the third option, a fixed add-on would be included in the update explicitly identified as blood-related cost adjustment. As we noted last time, this could be an unfortunate precedent that could lead other interested parties to come in with requests for similar add-ons for other products or costs. And in any case, the Congress considered and chose not to follow this route when it adopted BIPA last year.

Finally, blood costs could be addressed using the BIPA new technology pass-through provisions. However, these provisions were designed for technologies used by hospitals in the inpatient setting. They probably are not applicable to blood safety technologies used by blood banks that supply products to hospitals. Changes in costs such as those should be addressed through marketbasket adjustments for price changes.

In general, any interim adjustment to 2002 rates would entail a revision in the recommendation you made in your March report. In that recommendation you indicated that the update scheduled in law was appropriate and adequate to hospitals for fiscal year 2002. You may not want to modify that at this time and you certainly may not want to for as small a change as would probably be indicated for this case.

This is the draft language of the recommendation you discussed at the last meeting. It indicates the two alternatives are mutually exclusive and that we would expect CMS to consider both and choose between them. The alternatives basically are that CMS could reintroduce a separate cost component for blood in the hospital marketbasket, possibly using the producer price index for blood and derivatives as price proxy. This would be a return to a marketbasket design used before fiscal year 1997.

Alternatively, CMS could create a new marketbasket category for blood-related costs and other related costs. It would then

identify an appropriate price index to use as proxy. We present a specific example in the report which uses PPI for biologicals products as a possible proxy for a not completely specified cost category, as we discuss it in the report.

I should note that when CMS next revises the hospital marketbasket, which we expect to occur next year in preparation for the fiscal year 2003 rates, BIPA requires it to give special attention to the adequacy of payment for blood and blood products. These alternatives that we're discussing here are, we think, consistent with what BIPA requires. They would allow the marketbasket to better reflect changes in the prices of blood and blood products as new technologies are adopted during the next decade.

I'll take any questions at this point.

MR. HACKBARTH: Tim, help me understand how this would be reflected in the BLS statistics. I'm going to reveal my ignorance here -- but they're measuring price changes for -- at least theoretically -- constant products. To the extent that this is viewed as a different product, will this be picked up in their measures?

MR. GREENE: We think not. They do make quality and products change adjustments periodically. They tend to focus sophisticated analysis on things like computers and autos and other major products where they can get a reasonable measure of change and costs associated with change.

We understand, from speaking to BLS, that they wouldn't expect to make such quality change adjustments in the blood and related areas.

DR. NEWHOUSE: But they have discretion about whether they want to treat it as a new product. They can just ignore it and say the price went up 20 percent.

DR. ROWE: I think that there are two pieces here. One is that there are different products like a blood product that has been cleansed of its leukocytes or something like that. You could label it as a different product. But the other piece of this is that some of these emerging technologies, which are very expensive and will be very widely used, like viral inactivation, probably are not going to qualify as a separate product. It's a way that the given blood product or these packed red blood cells, whole blood, leuko-reduced blood or what it is, is treated. Everything is going to get this treatment. It's very expensive and it's kind of a technological advance rather than a new product.

I don't know whether the BLS or whatever it is, the mechanism would capture that or not. But I think there are two different things here.

MR. GREENE: That's true.

MR. HACKBARTH: My concern would be that we would say, this is not a change in the hospital product. That's why we don't think it's appropriate for the technology adjustment. This is a change in input. And so we say we ought to have a good measure

of input price changes, a better one than we've got now. And that will capture this increased cost to hospitals. And that's how it ought to flow through the Medicare payment system.

If, on the other hand, then BLS says well, this is a product change and we're just going to measure the price change for old fashioned blood, then there's a catch-22.

DR. ROWE: They're not capturing the real change. Why is it not an S&TA change? Because it's not something that's occurring in the hospital?

MR. HACKBARTH: THE hospital is not producing it. It's the change in an input that the hospital is using.

DR. ROSS: Just to clarify, it's because of the approach that we've been discussing, and will be discussing more this afternoon. The S&TA is built in. It's not that we're not accounting for it. It's that we're not identifying every individual component separately.

DR. ROWE: I understand that. I'm just remembering -- it's been a year, but remembering how hospitals run, we don't get all of our blood from the Red Cross. People go to the hospital and donate blood. They donate their own blood. They donate blood for their friends. That blood gets used in the hospital. Somebody is paying the salaries of people. It gets leuko-reduced in the hospital, I bet. It gets virally inactivated in the -- I mean, it's not all bought on the market. And so there is a -- my guess would be that some hospitals buy more than other hospitals. But I'm just not sure it's purely -- I don't know how to handle it.

DR. ROSS: Jack, that again is one of the reasons why you don't unbundle all the individual components.

MR. GREENE: Just for your information, Jack, it is done by hospitals but 7 percent of the country's blood is collected by hospitals. The rest is purchased. The vast amount of blood is bought from the market.

MR. HACKBARTH: Given that, it would be captured through an input price measure change, if in fact, this sort of change is captured by the BLS measures. That's my question.

DR. NEWHOUSE: This was sufficiently small scale that I wasn't concerned, but it seems to me, given your concern, you would want to know how BLS was, in fact, treating this. And that should be known because these are products that are on the market. The BLS can be asked what they're -- this just is coming in as they're ignoring the change in product for the purpose of the PPI.

MR. GREENE: My discussions with the BLS staffer that is in charge of this index indicated no awareness or concern with quality adjustment, really making the point we reserve our quality adjustment for very different sorts --

DR. NEWHOUSE: Quality adjustment isn't quite --

MR. GREENE: New product adjustment, the same general question.

DR. NEWHOUSE: So they're just ignoring it?

MR. GREEN: Yes, right.

MR. HACKBARTH: So that's good from our perspective. Okay.

DR. LOOP: Before I get into the options, I wonder if the cost of blood nationally is not underestimated, because there has been some testimony that the bill nationally is more than $4 billion. So Medicare would account for at least half of that.

By our calculations, this would not be 0.1 percent, which I'm afraid influences our thinking. It might be closer to 0.5 percent, the price increase. And if that's the case, then the high users of blood, which are not spread evenly across 5,000 hospitals, might have as much as a 1 percent cost increase.

This worries me that our original numbers are perhaps not correct and the small price increase is influencing the way we choose the options.

MR. GREENE: I based my 0.1 percent on starting with that 0.6 percent share used in marketbasket before 1997, which is also consistent with the numbers I get from my patient stay analysis, Medicare data. And say with a 20 percent increase in that, that adds 0.1 percentage point to overall hospital costs.

DR. ROWE: If we go in the direction that's proposed -- and I certainly support paying for this somehow, even though everybody seems to think it's a small amount, because I remember it seeming to be a big number in my budget, a lot of patients get blood. In the outpatient department, they get it from the visiting nurse. Increasingly patients are managed outside the hospital who are Medicare beneficiaries. So I want to make sure I understand how, if we make this change in this marketbasket on the hospital payment, does that influence the outpatient payment for blood or Carol's staff hanging blood in the home?

MR. HACKBARTH: The question asked was specific to hospital inpatient PPS. That's what we're addressing here.

MR. GREENE: Yes, and that's all our analysis addressed.

DR. ROWE: But Congress may not be aware. Our job is to answer that question, but also not to put blinders on. I mean, if Medicare beneficiaries are getting blood in the outpatient department which is also virally inactivated and leuko-reduced and everything else, we just want to make sure -- the economists here have taught me over the years that you don't want to set up a situation where the cost is deciding the site of care. Isn't that one of the rules? Or the payment is inducing the site of care.

We don't want to pay very well for an inpatient transfusion and not an outpatient transfusion, and wind up having that drive the site of care. Right?

DR. NEWHOUSE: Alas, it's a principle and not a rule.

DR. ROSS: I think it's reasonable to expect though that when CMS is revising the marketbasket and doing so on the inpatient side that it's going to look at all the price indexes that it uses.

MR. ASHBY: There's only one index. There's only one index that's applied to both inpatient and outpatient. So if you solve

it for inpatient, you automatically solve it for outpatient.

DR. ROWE: But we might have a sentence in the narrative that says they should be aware of that.

MR. MULLER: One of the questions last time, when we went through all the reweightings discussion and so forth, given the 1 percent increase that you've just estimated, when would this take effect? The marketbasket is done this year or next year. And the reweightings that Joe was educating us on last time, when would that take effect as it reweights against the charges for the DRGs?

MR. GREENE: If it proceeds on the schedule we're talking about, the new marketbasket, revised marketbasket and other factors would be included in the PPS proposed rule next spring and then reflected in payments in October.

MR. MULLER: I'll make the point again I made last month. 0.1 percent these days can be, depending on the inflationary value, can be a big number or a small number.

MR. HACKBARTH: Any other --

DR. NEWHOUSE: To go back to Ralph's point about reweighting, that's the answer, I think, to Floyd's issue that it's a one-time hit insofar as the difference across hospitals is really a function of surgical volume in use of blood. So that once it feeds into the weights, that will pick that up.

DR. LOOP: But we have to discuss what we're going to do in the interim until these are picked up because that's a big expense for some of the high users.

MR. GREENE: I looked at the effect on weights, and it's modest. A lot of weights go up, looking at the possible increases in charges, but only a slight amount because these cases typically are very expensive cases. So even a large blood cost is a small share of total cost.

MR. HACKBARTH: Refresh my recollection about the update.

MR. MULLER: I would just wonder if -- I think Floyd's point, and I would make mine and maybe some others. It can be a very high proportion of costs in some of these. It can be 25 or 30 percent of the costs in some of these cases.

MR. GREENE: Medicare data shows a few with more than 10 percent.

DR. ROWE: Ralph, you're thinking of the same experience I had, which is the hemophiliacs, and they probably are not Medicare beneficiaries. Those are the big, big expenses, huge utilization. That may not be relevant to this population.

MR. HACKBARTH: Let's talk about where we left the update last spring. As I recall, in essence what we said was we didn't have reason to disagree with what was written in current law, which was marketbasket minus 0.55 percent. So in that decision, and the wording of it, we acknowledged that we're talking about a range around this. And we just couldn't say that this was not the right number.

To now then come back and say we've got to reopen that decision for something of this magnitude, I think feels to me

inconsistent with the spirit of the March recommendation, which was this is a rough justice that we're talking about. And now we're talking about a relatively small cost. The two just don't go hand in hand.

Now if we had said we can account for everything and marketbasket minus 0.55 is precisely the right answer, now we have to update that to reflect this small amount, that might make sense. But that's not what we said. We said this is really crude. We acknowledged the reality that it's really crude.

So I just don't feel like going back for this small a number would be consistent.

MR. GREENE: In effect you could say marketbasket minus 0.45 is now our chosen number. Does that make sense as a change?

MR. HACKBARTH: I don't think that's consistent with the spirit of our spring analysis, and the other things that we have.

DR. ROWE: If that's not where you want to go, where do you want to go?

MR. HACKBARTH: I've got a suggestion on the draft recommendation, the language of it, which I think streamlines it a bit. I suggest we say that when CMS next revises the hospital marketbasket it should explicitly account for the cost of blood. And then we can, in the text, talk about the indexes and that sort of stuff. And just have a simple straightforward statement.

MR. GREENE: And eliminate both the bullet points in the recommendation, moving them into the discussion language?

MR. HACKBARTH: Right. When CMS next revises the hospital marketbasket, it should explicitly account for the cost of blood.

MR. GREENE: That's the entire recommendation?

MR. HACKBARTH: Right. As opposed to the current situation where it's like chemicals and...

DR. REISCHAUER: That's just a little less specific but it's the same thing. And I thought why we were into this game at all was not because of where we are today but looking out 10 years and understanding what's likely to happen to our ability to refine blood products. This might, over time, be a component. I mean, I don't lose sleep when I look at this and see that, relative to the overall operating costs per discharge, the differences here are trivial. What might occur, I think, in the future.

MR. HACKBARTH: One of the reasons I like the revised language is it's a little stronger than one that has these technical statements in the bullets. This could be a big factor down the road. We ought to explicitly account for it. And then we can talk in the text about the mechanisms.

MR. GREENE: One possible interpretation of that might be just point one. Do you want us to make clear that it's either one or two? Or do you just want point one?

MR. MULLER: Glenn, the way I read yours is to mean one. Is that correct?

MR. GREENE: Or one or two, both in a sense explicitly.

MR. MULLER: The problem I would say with two is the problem

we had five years ago when they lumped it into chemicals. And we wouldn't want to define this problem away by somebody saying oh, it's trivial anyway. The whole point of this long discussion was it may be a big cost, as Bob just said, and therefore we should recognize it. So if your wording means one, then I think it's a good wording.

DR. NEWHOUSE: Let me suggest a friendly amendment because I worried about the same thing. CMS could say their index now specifically accounts for it, they just measure chemicals. So it should use an index that measures the cost of blood.

MR. GREENE: Because the biological index that we discuss does indirectly, 10 percent of that is blood costs.

DR. ROWE: From a clinical point of view, in the evolution of things, this is not a biological, in the biological category or the chemical category. It's its own category. It's no longer blood, it's platelets, plasma, packed red blood cells, and this and that. It's become a whole category itself, and that's what we're saying is we don't want to dump it into one or another and we should recognize it as an emerging category.

DR. ROSS: Let me propose with the simplification, that that gets at the objective here. The bullet points or the friendly amendment are sort of means to that objective. We could incorporate those in text, I think, just as easily. But you want us to make sure blood is explicitly taken into account.

DR. LOOP: This will take a couple of years to get in?

MR. GREENE: On the expected schedule, it would take effect next October 1st with payments beginning October 1st. We don't know that for certain, but given the anticipated schedule.

DR. LOOP: Since the blood prices went up in July, that means more than a year of absorbing pretty large costs for those hospitals that are large tertiary referral centers that have a big Medicare population. Are we sensitive to that?

MR. HACKBARTH: I guess the issue, Floyd, is is this, in fact, large in the grand scheme of things?

DR. LOOP: I can tell you from my personal experience that it's not a 20 percent increase, it's 30 percent where we are. And it costs our hospital $2.5 million.

MR. HACKBARTH: I guess the question is, what is the base? What is the denominator on that? And the denominator is very large. So as a percent increase, this is not very large. I think that's what the argument's about, or the discussion is about.

DR. LOOP: It's still money. It may not be large but...

DR. ROSS: I guess the point I would make earlier is that again, we're focused on one particular item, the price of which we know has gone up. But what we haven't examined also is all the other inputs to the process this year whose prices have gone down, whether it's been recent changes in fuel oil or anything else. And it makes it difficult just to pull one thing out and say yes, this one has gone up. There's no argument there. We know that.

DR. LOOP: Yes, but we're not transfusing fuel oil. We have a problem --

DR. ROSS: Actually, according to the marketbasket index, you are.

[Laughter.]

DR. LOOP: I think you're being insensitive to a large component of the hospital industry by saying that over the next 15 months or so, they just have to absorb the cost. Now if you spread it all across the hospital industry it's almost a rounding error, but not for the high end users.

DR. REISCHAUER: But the way our system works, when prices are rising, hospitals get hit. And whether it's fuel oil or anything else, when they're rising slower than they did the year before, the index, in a sense, overcompensates.

DR. LOOP: But, Bob, this is not 1970. There's less padding in the hospitals now. That's the big problem. And there's barely a profit margin. When you add unreimbursed costs to it, even if it's for a year or so, it makes a big difference.

MR. GREENE: Just one point. The 20 percent really is an exceptional number. The PPI was going up a little bit less than 10 percent, and actually declined last year, and is now increasing again. So you shouldn't think of this 20 percent curve that's going up nonstop and continuously. That's the exception.

If anything, in 2000 the PPI went down.

DR. ROWE: Is there any way to -- what we want to do, if I'm listening to what Floyd's saying, what I'm hearing is that we're going to make this change in the due course of things and we're shining a light on blood and blood products as it may emerge as a future issue that stands upon itself as important. But in the usual course of things, the payments will not increase for some period of time.

Floyd's point is there are some hospitals which are particularly susceptible to the adverse effect of this uncompensated increase in price. Do we have any history of dealing with that kind of a question, so that some subset of hospitals that are particularly high users of one or another service get a corrected payment in some way? Has that ever happened? Does Medicare ever do that?

DR. NEWHOUSE: Not that I know of, and it would land us in a much more general problem, which is that basically we use the same marketbasket weights for every hospital. The issue here is that not every hospital has the same marketbasket. But then you open yourself up to every hospital coming in and saying well, we have a different marketbasket than the average and this particular component went up. Therefore we want relief.

The system would just break down.

DR. ROWE: I'm just asking. For all I know there was some mechanism that had been used at some point.

MR. MULLER: Joe, how quickly, let's say if these 20 percent increases that should, other things being equal, kick these DRGs

into outlier status more quickly, right? Or not?

DR. NEWHOUSE: Yes, that's also true. So to the degree that that's true, that would take effect immediately. But I wouldn't count on much relief from that, because the outliers are still a pretty small fraction of cases. But yes, it does help.

MR. GREENE: It's 20 percent on 5 percent costs.

MR. HACKBARTH: It feels to me like we're covering the same ground over and over.

DR. LOOP: Let me introduce a little new ground. I thought we were going to review the DRGs that were involved with the high blood usage? I think, as I remember from last time, we talked about 132 DRGs or something that had some kind of blood usage related to them. Is there not a way, for a short period of time, to add something to the blood DRG that would compensate the hospital in the short-run?

MR. GREENE: I've looked at the DRG distribution in changes, an estimate of what would the impact be when we recalibrate DRGs, looking at the impact of a 20 percent increase in blood product costs on charges. And there I found 132 DRGs being affected positively, have blood costs that would lead to higher charges. But none increasing by as much as 1 percent. None with relative charges increasing as much as 1 percent. So there is an effect, but it's a small effect overall, even on the blood use DRGs.

MR. HACKBARTH: Floyd, let's think for a second about the process by which changes like this would be made. If in fact, they require legislative change, then you're talking about it, in all likelihood, happening next year for implementation at the beginning of the fiscal year anyhow. And so you haven't really solved the lag problem if that's the problem we're going after. It's not like these things will happen instantaneously.

DR. LOOP: That's the problem. As Jack pointed out earlier, there's going to be new technologies to remove all pathogens from blood, and that's going to jack the price up another 20 or 30 percent, and then there will be another lag period. So we're going to face this again.

DR. ROSS: But a marketbasket that better accounts for blood products, again in terms of making updates, it's a forecast marketbasket. And looking forward with a separate component, one would hope that those additional increases down the road could be taken into account.

MR. HACKBARTH: We need to bring this to a conclusion. What I propose we do is vote on the recommendation that's before us as amended. Let me go back and restate what that is.

Then the issue that we seem to be hung up on is whether something needs to be done during this lag period. And if Floyd or another commissioner wants to make a proposal on that, we can vote on that as well. I feel like we're just sort of stuck here, going back and forth over the same ground.

DR. LOOP: The problem with that, with making a proposal for a short-term fix is that it either sets a precedent and other people would put their baggage in on it. I don't know how you

can make a proposal to this, but you have hundreds of hospitals that are affected by huge increase in prices for blood. And it will affect their bottom line.

So I think the Commission has to be sensitive to that. I don't know how to fix it in the short-term because there's no precedent for it.

MR. HACKBARTH: So you're saying that --

DR. LOOP: If you make a pass-through or you add something on to a DRG, then you guys have effectively argued that this --

MR. HACKBARTH: -- will be delayed and will open the door.

DR. LOOP: Exactly.

DR. NEWHOUSE: Also, I don't think HCFA would have statutory authority to do that unless it was budget neutral, in which case you'd wind up taking money away from other hospitals. And then they would come in and say why are you taking it away.

MR. HACKBARTH: As an add-on it has to be a statutory change, which will result in lags.

DR. ROSS: Can I propose then at least to add text language in here noting that the distributional impact is concentrated in particular DRGs and more likely to be in particular kinds of hospitals? Does that address part of it?

DR. LOOP: I appreciate that, Murray. All advice should be accompanied by a check.

MR. HACKBARTH: Are we ready to vote?

MR. MULLER: This is your wording?

DR. ROSS: The wording is, when CMS next revises the hospital marketbasket it should explicitly account for the cost of blood and blood products?

DR. ROWE: Blood products.

DR. ROSS: Just blood products. I'll read it again.

When CMS next revises the hospital marketbasket, it should explicitly account for the cost of blood products.

MR. MULLER: Would you mind my suggestion, [inaudible].

DR. NEWHOUSE: I agree. CMS can say what they're doing now.

MR. MULLER: So if you wouldn't mind keeping point one and scratching point two, because two maybe gets us in the kind of difficulty we had the last five years.

DR. ROWE: We want to get it out of chemicals and biologicals rather than have them saying we are explicitly including it.

DR. REISCHAUER: I don't see that saving the first bullet changes it at all, because they could say well, we'll do chemicals.

DR. ROWE: But it's not a separate component.

MR. MULLER: I was just trying to strike two.

DR. NEWHOUSE: That explicitly measures the price of blood. It's a separate component that explicitly measures the price of blood.

DR. ROSS: That's where we were.

MR. HACKBARTH: Maybe in the text we can say, we're not

talking about a chemical surrogate for blood. What this means is what it says on the face. We want to measure blood, as opposed to trying to fiddle with the recommendation language.

MR. GREENE: There's language in the report already talking about the chemicals versus blood.

MR. HACKBARTH: I think in the context it's clear that we're not happy with the current situation.

All opposed?

All in favor?

Abstain?

Thanks, Tim.